FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041939

Facility Name: WILLOWCREEK REHAB AND NSG

Address: 40 N. 64TH STREET (Number) BELLEVILLE (City) 62223 (Zip Code)

County: ST. CLAIR

Telephone Number: (618) 397-8400 **Fax #** (618) 397-8470

IDPA ID Number: 364084188001

Date of Initial License for Current Owners: 06/01/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) MARVIN FOX, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	60	Skilled (SNF)	60	21,900	1
2		Skilled Pediatric (SNF/PED)			2
3	62	Intermediate (ICF)	62	22,630	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	122	TOTALS	122	44,530	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	19,937	2,067	7,891	29,895	8
9	SNF/PED					9
10	ICF	7,353	523		7,876	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,290	2,590	7,891	37,771	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.82%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/01/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/01/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 122 and days of care provided 6677

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	175,377	7,778	7,036	190,191		190,191	20,769	210,960			1
2	Food Purchase		166,611		166,611	(13,797)	152,814	(107)	152,707			2
3	Housekeeping	105,018	23,079		128,097		128,097		128,097			3
4	Laundry	55,606	24,922		80,528		80,528		80,528			4
5	Heat and Other Utilities			98,533	98,533		98,533	878	99,411			5
6	Maintenance	79,427		47,745	127,172		127,172	(1,096)	126,076			6
7	Other (specify):*											7
8	**TOTAL General Services**	415,428	222,390	153,314	791,132	(13,797)	777,335	20,443	797,778			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	2,025,562	182,445	102,211	2,310,218		2,310,218	(56,995)	2,253,223			10
10a	Therapy	81,365	15,297	37,238	133,900		133,900	(1,647)	132,253			10a
11	Activities	58,569	4,378		62,947		62,947		62,947			11
12	Social Services	9,051		3,300	12,351		12,351		12,351			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							2,760	2,760			15
16	**TOTAL Health Care and Programs**	2,174,547	202,120	149,949	2,526,616		2,526,616	(55,882)	2,470,734			16
	C. General Administration											
17	Administrative	77,617		278,881	356,498		356,498	(177,684)	178,814			17
18	Directors Fees											18
19	Professional Services			47,346	47,346		47,346	(1,586)	45,760			19
20	Dues, Fees, Subscriptions & Promotions			76,424	76,424		76,424	(50,666)	25,758			20
21	Clerical & General Office Expenses	136,773	45,000	226,461	408,234		408,234	(111,952)	296,282			21
22	Employee Benefits & Payroll Taxes			487,819	487,819	13,797	501,616		501,616			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,759	2,759		2,759	(322)	2,437			24
25	Other Admin. Staff Transportation			17,126	17,126		17,126	(2,162)	14,964			25
26	Insurance-Prop.Liab.Malpractice			67,620	67,620		67,620	13	67,633			26
27	Other (specify):*							27,915	27,915			27
28	**TOTAL General Administration**	214,390	45,000	1,204,436	1,463,826	13,797	1,477,623	(316,444)	1,161,179			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,804,365	469,510	1,507,699	4,781,574		4,781,574	(351,883)	4,429,691			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number WILLOWCREEK REHAB AND NSG #0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			91,648	91,648		91,648	5,358	97,006			30
31	Amortization of Pre-Op. & Org.			55,404	55,404		55,404		55,404			31
32	Interest			150,329	150,329		150,329	307	150,636			32
33	Real Estate Taxes			47,956	47,956		47,956		47,956			33
34	Rent-Facility & Grounds			414,594	414,594		414,594	8,477	423,071			34
35	Rent-Equipment & Vehicles			9,426	9,426		9,426	807	10,233			35
36	Other (specify):*							(2,510)	(2,510)			36
37	**TOTAL Ownership**			769,357	769,357		769,357	12,439	781,796			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	397,279	748,766	667,399	1,813,444		1,813,444	(87,775)	1,725,669			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,795	66,795		66,795		66,795			42
43	Other (specify):*	14,994			14,994		14,994	(14,994)				43
44	**TOTAL Special Cost Centers**	412,273	748,766	734,194	1,895,233		1,895,233	(102,769)	1,792,464			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,216,638	1,218,276	3,011,250	7,446,164		7,446,164	(442,213)	7,003,951			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,714)	30		9
10	Interest and Other Investment Income	(958)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(107)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(391)	21		18
19	Entertainment				19
20	Contributions	(800)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(176,562)	21		24
25	Fund Raising, Advertising and Promotional	(46,359)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(7,056)	20		28
29	Other-Attach Schedule	(43,732)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (279,679)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(162,534)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (162,534)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (442,213)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

WILLOWCREEK REHAB AND NSG

ID# 0041939

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	IDPH Penalty	$ (1,551)	32	1
2	Marketing Salary	(14,994)	43	2
3	Bank Charges	(20,423)	21	3
4	Political Contributions - ICLTC	(2,241)	20	4
5	Out of Period Seminar Expense	(600)	24	5
6	Capitalized Repairs & Maintenance	(1,241)	6	6
7	Non-Allowable Legal Expense	(520)	19	7
8	Prior Period Auto Costs	(396)	25	8
9	Marketing Travel Cost	(1,766)	25	9
10				10
11				11
12				12
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91				91

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				(2,245)						23,013		20,769	1
2	Food Purchase	(107)											(107)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			703			175						878	5
6	Maintenance	(1,241)		28			117						(1,096)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(1,348)		731	(2,245)		292				23,013		20,443	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			10,954			4,480				(72,429)		(56,995)	10
10a	Therapy								(941)	(706)			(1,647)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			1,798			962						2,760	15
16	**TOTAL Health Care and Programs**			12,752			5,442		(941)	(706)	(72,429)		(55,882)	16
	C. General Administration													
17	Administrative			58,992	(189,987)	5,368	36,837	(88,894)					(177,684)	17
18	Directors Fees													18
19	Professional Services	(520)		3,547		(7,815)	3,202						(1,586)	19
20	Fees, Subscriptions & Promotions	(55,656)		3,486		28	1,476						(50,666)	20
21	Clerical & General Office Expenses	(198,176)		49,836		7,868	28,520						(111,952)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(600)		100			178						(322)	24
25	Other Admin. Staff Transportation	(2,162)											(2,162)	25
26	Insurance-Prop.Liab.Malpractice			12			1						13	26
27	Other (specify):*			14,777		257	12,881						27,915	27
28	**TOTAL General Administration**	(257,114)		130,750	(189,987)	5,706	83,095	(88,894)					(316,444)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(258,462)		144,233	(192,232)	5,706	88,829	(88,894)	(941)	(706)	(49,416)		(351,883)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(3,714)		7,510		1,268	294						5,358	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,509)		1,846		973	(3)						307	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds			5,744			2,733						8,477	34
35	Rent-Equipment & Vehicles				600		207						807	35
36	Other (specify):*					(2,510)							(2,510)	36
37	**TOTAL Ownership**	(6,223)		15,100	600	(269)	3,231						12,439	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(28,484)	(31,231)	(28,060)		(87,775)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(14,994)											(14,994)	43
44	**TOTAL Special Cost Centers**	(14,994)							(28,484)	(31,231)	(28,060)		(102,769)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(279,679)		159,333	(191,632)	5,437	92,060	(88,894)	(29,425)	(31,937)	(77,476)		(442,213)	45

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	QUALITY CARE MANAGEMENT	100.00%	$ 703	$ 703	15
16	V	6	REPAIRS AND MAINT.		QUALITY CARE MANAGEMENT	100.00%	28	28	16
17	V	10	SAL-NURSING		QUALITY CARE MANAGEMENT	100.00%	10,036	10,036	17
18	V	10	NURS SAL-M. CLARKE		QUALITY CARE MANAGEMENT	100.00%	918	918	18
19	V	15	EMP. BEN.-H.C.		QUALITY CARE MANAGEMENT	100.00%	1,798	1,798	19
20	V	17	ADMIN SAL-NON-OWNER		QUALITY CARE MANAGEMENT	100.00%	14,387	14,387	20
21	V	17	ADMIN. SAL.- A. SALTZMAN		QUALITY CARE MANAGEMENT	100.00%	2,442	2,442	21
22	V	17	ADMIN. SAL - B BENOUDIZ		QUALITY CARE MANAGEMENT	100.00%	8,042	8,042	22
23	V	17	ADMIN. SAL. - B. CLOCH		QUALITY CARE MANAGEMENT	100.00%	21,157	21,157	23
24	V	17	ADMIN. SAL. - B. TEITELBAUM		QUALITY CARE MANAGEMENT	100.00%	3,075	3,075	24
25	V	17	ADMIN. SAL - J. MEISELS		QUALITY CARE MANAGEMENT	100.00%	1,265	1,265	25
26	V	17	ADMIN. SAL. - STEVE VAN CAMP		QUALITY CARE MANAGEMENT	100.00%			26
27	V	17	ADMIN. SAL. - MIKE FILIPPO		QUALITY CARE MANAGEMENT	100.00%	8,624	8,624	27
28	V	19	PROFESSIONAL FEES		QUALITY CARE MANAGEMENT	100.00%	3,547	3,547	28
29	V	20	FEES,SUBSCRIPTIONS		QUALITY CARE MANAGEMENT	100.00%	3,486	3,486	29
30	V	21	CLERICAL & GENERAL		QUALITY CARE MANAGEMENT	100.00%	44,575	44,575	30
31	V	21	ACCTG SAL-B. LARIMORE		QUALITY CARE MANAGEMENT	100.00%	3,526	3,526	31
32	V	21	OFFICE SAL-M. CLOCH		QUALITY CARE MANAGEMENT	100.00%	1,735	1,735	32
33	V	24	EDUCATION & SEMINAR		QUALITY CARE MANAGEMENT	100.00%	100	100	33
34	V	26	INSURANCE		QUALITY CARE MANAGEMENT	100.00%	12	12	34
35	V	27	EMP. BEN.-GEN. ADMIN.		QUALITY CARE MANAGEMENT	100.00%	14,777	14,777	35
36	V	30	DEPRECIATION		QUALITY CARE MANAGEMENT	100.00%	7,510	7,510	36
37	V	32	INTEREST		QUALITY CARE MANAGEMENT	100.00%	1,846	1,846	37
38	V	34	OFFICE RENT-UNRELATED		QUALITY CARE MANAGEMENT	100.00%	5,744	5,744	38
39	Total			$			$ 159,333	$ * 159,333	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	EQUIPMENT RENTAL	$	QUALITY CARE MANAGEMENT	100.00%	$ 600	$ 600	15
16	V								16
17	V	17	CORPORATE ALLOCATION	189,987	QUALITY CARE MANAGEMENT	100.00%		(189,987)	17
18	V								18
19	V	6	REPAIRS AND MAINT.		QUALITY CARE MANAGEMENT	100.00%			19
20	V	7	EMP. BEN.-GEN. SERV.		QUALITY CARE MANAGEMENT	100.00%			20
21	V								21
22	V	1	DIETICIAN SALARIES	2,245	QUALITY CARE MANAGEMENT	100.00%		(2,245)	22
23	V	7	EMP. BEN.-GEN. ADMIN.		QUALITY CARE MANAGEMENT	100.00%			23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 192,232			$ 600	$ * (191,632)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN SAL-NON-OWNER	$	QUALITY CARE MANAGEMENT	100.00%	$ 726	$ 726	15
16	V	17	ADMIN. SAL. - B. CLOCH		QUALITY CARE MANAGEMENT	100.00%	2,321	2,321	16
17	V	17	ADMIN. SAL. - B. TEITELBAUM		QUALITY CARE MANAGEMENT	100.00%	1,644	1,644	17
18	V	17	ADMIN. SAL - J. MEISELS		QUALITY CARE MANAGEMENT	100.00%	677	677	18
19	V	19	PROFESSIONAL FEES		QUALITY CARE MANAGEMENT	100.00%	185	185	19
20	V	17	MGNT FEES-DIRECT ALLOC		QUALITY CARE MANAGEMENT	100.00%	88,894	88,894	20
21	V	20	FEES,SUBSCRIPTIONS		QUALITY CARE MANAGEMENT	100.00%	28	28	21
22	V	21	CLERICAL & GENERAL		QUALITY CARE MANAGEMENT	100.00%	7,868	7,868	22
23	V	27	EMP. BEN.-GEN. ADMIN.		QUALITY CARE MANAGEMENT	100.00%	257	257	23
24	V	30	DEPRECIATION		QUALITY CARE MANAGEMENT	100.00%	1,268	1,268	24
25	V	32	INTEREST		QUALITY CARE MANAGEMENT	100.00%	973	973	25
26	V	36	GAIN ON SALE OF ASSETS		QUALITY CARE MANAGEMENT	100.00%	(2,510)	(2,510)	26
27	V								27
28	V	17	CORPORATE ALLOCATION	88,894	QUALITY CARE MANAGEMENT	100.00%		(88,894)	28
29	V	19	COMPUTER SERVICES	8,000	QUALITY CARE MANAGEMENT	100.00%		(8,000)	29
30	V								30
31	V	1	DIETICIAN SALARIES		QUALITY CARE MANAGEMENT	100.00%			31
32	V	7	EMP. BEN.-GEN. ADMIN.		QUALITY CARE MANAGEMENT	100.00%			32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 96,894			$ 102,331	$ * 5,437	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	$ 175	$ 175	15
16	V	6	REPAIRS AND MAINT.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	117	117	16
17	V	10	NURSING		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	595	595	17
18	V	10	SAL-NURSING-M. CLARKE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	3,885	3,885	18
19	V	15	EMP. BEN.-H.C.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	962	962	19
20	V	17	ADMIN SAL-NON-OWNER		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	8,757	8,757	20
21	V	17	ADMIN. SAL.- F. BENJAMIN		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	6,925	6,925	21
22	V	17	ADMIN. SAL - B BENOUDIZ		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	4,990	4,990	22
23	V	17	ADMIN. SAL. - B. CLOCH		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	5,858	5,858	23
24	V	17	ADMIN. SAL. - C. ROSS		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	694	694	24
25	V	17	ADMIN. SAL - S. VAN CAMP		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	4,307	4,307	25
26	V	17	ADMIN. SAL. - M. FILIPPO		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	5,306	5,306	26
27	V	17	ADMIN. SAL. - J. ELOWE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%			27
28	V	19	PROFESSIONAL FEES		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	3,202	3,202	28
29	V	20	FEES,SUBSCRIPTIONS		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	1,476	1,476	29
30	V	21	CLERICAL & GENERAL		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	26,864	26,864	30
31	V	21	SALARIES-ACCTG-B. LARIMORE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	1,656	1,656	31
32	V	24	EDUCATION & SEMINAR		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	178	178	32
33	V	26	INSURANCE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	1	1	33
34	V	27	EMP. BEN.-GEN. ADMIN.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	12,881	12,881	34
35	V	30	DEPRECIATION		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	294	294	35
36	V	32	INTEREST		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	(3)	(3)	36
37	V	34	OFFICE RENT-UNRELATED		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	2,733	2,733	37
38	V	35	EQUIPMENT RENTAL		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	207	207	38
39	Total			$			$ 92,060	$ * 92,060	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	CORP ALLOC/MGMT FEE	88,894	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	$	$ (88,894)	15
16	V								16
17	V	6	REPAIRS AND MAINT.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%			17
18	V	7	EMP. BEN.-GEN. SERV.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%			18
19	V								19
20	V	1	DIETICIAN SALARIES		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%			20
21	V	7	EMP. BEN.-GEN. ADMIN.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%			21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 88,894			$	$ * (88,894)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	REHAB CONSULTING	$ 14,096	AT&R II, LLC	100.00%	$ 13,155	$ (941)	15
16	V	39	ANCILLARY REHAB	426,404	AT&R II, LLC	100.00%	397,920	(28,484)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 440,500			$ 411,075	$ * (29,425)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	REHAB CONSULTING	$ 5,141	Advanced Therapy and Rehab, LLC	100.00%	$ 4,435	$ (706)	15
16	V	39	ANCILLARY REHAB	227,462	Advanced Therapy and Rehab, LLC	100.00%	196,231	(31,231)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 232,603			$ 200,666	$ * (31,937)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	MEDICAL/TUBE FEED-MDCR	$ 46,728	QUALITY CARE MEDICAL SUPPLY	100.00%	$ 18,668	$ (28,060)	15
16	V	10	MEDICAL SUPPLIES	82,292	QUALITY CARE MEDICAL SUPPLY	100.00%	9,863	(72,429)	16
17	V	1	FOOD SUPPLEMENTS		QUALITY CARE MEDICAL SUPPLY	100.00%	23,013	23,013	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 129,020			$ 51,544	$ * (77,476)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Brian Cloch	Owner	Administrative	46.00%	See Attached	5.33	8.20%	Alloc.-QCM	$ 23,478	17-7	1
2	Brian Cloch	Owner	Administrative	46.00%	See Attached	5.33	8.20%	Alloc.-Blvd	5,858	17-7	2
3	Beth Benoudiz	CFO	Administrative	4.00%	See Attached	4.54	9.08%	Alloc.-QCM	8,042	17-7	3
4	Beth Benoudiz	CFO	Administrative	4.00%	See Attached	4.54	9.08%	Alloc.-Blvd.	4,990	17-7	4
5	David Meisels	Owner	Administrative	46.00%	See Attached	5	9.09%				5
6	Amy Saltzman	Owner	Administrative	4.00%	See Attached	1.35	10.80%	Alloc.-QCM	2,442	17-7	6
7	Brucha Teitelbaum	Relative	Administrative		See Attached	.69	1.73%	Alloc.-QCM	4,719	17-7	7
8	Joseph Meisels	Relative	Administrative		See Attached	2.76	5.52%	Alloc.-QCM	1,942	17-7	8
9	Marilyn Cloch	Relative	Administrative		See Attached	2.4	6.00%	Alloc.-QCM	1,735	21-7	9
10											10
11											11
12											12
13								TOTAL	$ 53,206		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MANAGEMENT
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	258,551	8	$ 7,246	$		$ 703	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	258,551	8	290			28	2
3	10	SAL-NURSING	PATIENT DAYS	258,551	8	103,396	103,396		10,036	3
4	10	NURS SAL-M. CLARKE	PATIENT DAYS	258,551	8	9,458	9,458		918	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	258,551	8	18,527			1,798	5
6	17	ADMIN SAL-NON-OWNER	PATIENT DAYS	258,551	8	148,217	148,217		14,387	6
7	17	ADMIN. SAL.- A. SALTZMAN	DIRECT/PATIENT DAYS		6	22,590	22,590		2,442	7
8	17	ADMIN. SAL - B BENOUDIZ	PATIENT DAYS	258,551	8	82,852	82,852		8,042	8
9	17	ADMIN. SAL. - B. CLOCH	PATIENT DAYS	258,551	8	217,962	217,962		21,157	9
10	17	ADMIN. SAL. - B. TEITELBAUM	DIRECT/PATIENT DAYS		5	22,566	22,566		3,075	10
11	17	ADMIN. SAL - J. MEISELS	DIRECT/PATIENT DAYS		5	9,284	9,284		1,265	11
12	17	ADMIN. SAL. - STEVE VAN CA	DIRECT/PATIENT DAYS		3	10,508	10,508			12
13	17	ADMIN. SAL. - MIKE FILIPPO	PATIENT DAYS	258,551	8	88,849	88,849		8,624	13
14	19	PROFESSIONAL FEES	PATIENT DAYS	258,551	8	36,541			3,547	14
15	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	258,551	8	35,917			3,486	15
16	21	CLERICAL & GENERAL	PATIENT DAYS	258,551	8	459,219	364,702		44,575	16
17	21	ACCTG SAL-B. LARIMORE	DIRECT/PATIENT DAYS		7	35,710	35,710		3,526	17
18	21	OFFICE SAL-M. CLOCH	PATIENT DAYS	258,551	8	17,876	17,876		1,735	18
19	24	EDUCATION & SEMINAR	PATIENT DAYS	258,551	8	1,028			100	19
20	26	INSURANCE	PATIENT DAYS	258,551	8	121			12	20
21	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	258,551	8	152,231			14,777	21
22	30	DEPRECIATION	PATIENT DAYS	258,551	8	77,371			7,510	22
23	32	INTEREST	PATIENT DAYS	258,551	8	19,022			1,846	23
24	34	OFFICE RENT-UNRELATED	PATIENT DAYS	258,551	8	59,175			5,744	24
25	TOTALS					$ 1,635,956	$ 1,133,970		$ 159,333	25

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MANAGEMENT
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	35	EQUIPMENT RENTAL	PATIENT DAYS	258,551	8	$ 6,176	$		$ 600	1
2										2
3										3
4										4
5	6	REPAIRS AND MAINT.	PAINTING REVENUE	24,700	4	27,506	27,506			5
6	7	EMP. BEN.-GEN. SERV.	PAINTING REVENUE	24,700	4	4,515				6
7										7
8	1	DIETICIAN SALARIES	DIETICIAN REVENUE	34,652	8	42,478	42,478			8
9	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN REVENUE	34,652	8	6,973				9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 87,648	$ 69,984		$ 600	25

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MANAGEMENT
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMIN SAL-NON-OWNER	PATIENT DAYS	89,917	5	$ 5,150	$ 5,150	12,674	$ 726	1
2	17	ADMIN. SAL. - B. CLOCH	PATIENT DAYS	89,917	5	16,467	16,467	12,674	2,321	2
3	17	ADMIN. SAL. - B. TEITELBAUM	PATIENT DAYS	89,917	5	11,667	11,667	12,674	1,644	3
4	17	ADMIN. SAL - J. MEISELS	PATIENT DAYS	89,917	5	4,800	4,800	12,674	677	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	89,917	5	1,316		12,674	185	5
6	17	MGNT FEES-DIRECT ALLOC	DIRECT ALLOCATION		5	541,973			88,894	6
7	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	89,917	5	200		12,674	28	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	89,917	5	55,820		12,674	7,868	8
9	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	89,917	5	1,825		12,674	257	9
10	30	DEPRECIATION	PATIENT DAYS	89,917	5	8,999		12,674	1,268	10
11	32	INTEREST	PATIENT DAYS	89,917	5	6,900		12,674	973	11
12	36	GAIN ON SALE OF ASSETS	PATIENT DAYS	89,917	5	(17,809)		12,674	(2,510)	12
13										13
14										14
15										15
16										16
17	1	DIETICIAN SALARIES	DIETICIAN REVENUE	4,053	3	3,527	3,527			17
18	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN REVENUE	4,053	3	71				18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 640,906	$ 41,611		$ 102,331	25

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: BOULEVARD HEALTHCARE MANAGEMEN
Street Address: 8950 GROSS POINT RD. SUITE 600
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	147,139	8	$ 2,034	$	12,674	$ 175	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	147,139	8	1,354		12,674	117	2
3	10	NURSING	PATIENT DAYS	147,139	8	6,902	5,142	12,674	595	3
4	10	SAL-NURSING-M. CLARKE	PATIENT DAYS	147,139	8	45,100	45,100	12,674	3,885	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	147,139	8	11,172		12,674	962	5
6	17	ADMIN SAL-NON-OWNER	PATIENT DAYS	147,139	8	101,666	101,666	12,674	8,757	6
7	17	ADMIN. SAL.- F. BENJAMIN	PATIENT DAYS	147,139	8	80,400	80,400	12,674	6,925	7
8	17	ADMIN. SAL - B BENOUDIZ	PATIENT DAYS	147,139	8	57,937	57,937	12,674	4,990	8
9	17	ADMIN. SAL. - B. CLOCH	PATIENT DAYS	147,139	8	68,004	68,004	12,674	5,858	9
10	17	ADMIN. SAL. - C. ROSS	DIRECT/PATIENT DAYS		4	4,050	4,050	12,674	694	10
11	17	ADMIN. SAL - S. VAN CAMP	PATIENT DAYS	147,139	8	50,000	50,000	12,674	4,307	11
12	17	ADMIN. SAL. - M. FILIPPO	PATIENT DAYS	147,139	8	61,604	61,604	12,674	5,306	12
13	17	ADMIN. SAL. - J. ELOWE	AVERAGE HOURS	10	3	12,121	12,121			13
14	19	PROFESSIONAL FEES	PATIENT DAYS	147,139	8	37,170		12,674	3,202	14
15	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	147,139	8	17,139		12,674	1,476	15
16	21	CLERICAL & GENERAL	PATIENT DAYS	147,139	8	311,878	242,119	12,674	26,864	16
17	21	SALARIES-ACCTG-B. LARIMO	DIRECT/PATIENT DAYS		7	17,000	17,000	12,674	1,656	17
18	24	EDUCATION & SEMINAR	PATIENT DAYS	147,139	8	2,070		12,674	178	18
19	26	INSURANCE	PATIENT DAYS	147,139	8	13		12,674	1	19
20	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	147,139	8	149,543		12,674	12,881	20
21	30	DEPRECIATION	PATIENT DAYS	147,139	8	3,414		12,674	294	21
22	32	INTEREST	PATIENT DAYS	147,139	8	(39)		12,674	(3)	22
23	34	OFFICE RENT-UNRELATED	PATIENT DAYS	147,139	8	31,727		12,674	2,733	23
24	35	EQUIPMENT RENTAL	PATIENT DAYS	147,139	8	2,402		12,674	207	24
25	TOTALS					$ 1,074,661	$ 745,143		$ 92,060	25

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: BOULEVARD HEALTHCARE MANAGEMEN
Street Address: 8950 GROSS POINT RD. SUITE 600
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3	6	REPAIRS AND MAINT.	PAINTING REVENUE	8,632	2	7,120	7,120			3
4	7	EMP. BEN.-GEN. SERV.	PAINTING REVENUE	8,632	2	1,583				4
5						$	$			5
6	1	DIETICIAN SALARIES	DIETICIAN REVENUE	19,790	8	20,524	20,524			6
7	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN REVENUE	19,790	8	4,564				7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 33,791	$ 27,644		$	25

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: AT&R II, LLC
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847)663-1155
Fax Number: (847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	REHAB CONSULTING	DIRECT ALLOCATION						13,155	1
2	39	ANCILLARY REHAB	DIRECT ALLOCATION						397,920	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 411,075	25

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ADVANCED THERAPY AND REHAB, LLC
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847)663-1155
Fax Number: (847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	REHAB CONSULTING	DIRECT ALLOCATION						4,435	1
2	39	ANCILLARY REHAB	DIRECT ALLOCATION						196,231	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 200,666	25

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MEDICAL SUPPLY
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847)663-1155
Fax Number: (847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	MEDICAL/TUBE FEED-MDCR	DIRECT ALLOCATION						18,668	1
2	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						9,863	2
3	1	FOOD SUPPLEMENTS	DIRECT ALLOCATION						23,013	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 51,544	25

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	DVI		X	Line of Credit				926,706			13,573	6
7	VIASYS Healthcare		X	Equipment Purchase				181,571			13,420	7
8	Manufacturer's Bank		X	Working Capital				215,000			19,105	8
9	TOTAL Facility Related						$	$ 1,323,277			$ 46,098	9
	B. Non-Facility Related*											
10	See Supplemental Schedule						307,500	1,022,137			104,541	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 307,500	$ 1,022,137			$ 104,541	14
15	TOTALS (line 9+line14)						$ 307,500	$ 2,345,414			$ 150,639	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	CHMIT	X		Working Capital		06/01/96	$ 182,500	$ 182,500	Demand	8.00%	$ 14,600	1
2	J. Rosin		X	Working Capital	Interest Only	05/12/97	100,000	75,000	Demand	9.50%	7,125	2
3	Belleville Associates		X	Security Deposit Loan		06/01/97	25,000	25,000	N/A	10.00%	2,500	3
4	Corus Bank		X	Line of Credit							35,683	4
5	David Meisels	X									1,109	5
6	Continental Care Center	X		Working Capital				739,637			39,413	6
7	A.I. Credit	X									2,250	7
8	Interest Income										(958)	8
9	Alloc-Quality Care Mgmt.	X									2,819	9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$ 307,500	$ 1,022,137			$ 104,541	21

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	49,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	47,756	2
3. Under or (over) accrual (line 2 minus line 1).	$	(1,244)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	49,200	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	47,956	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996		8
1997	77,314	9
1998	46,265	10
1999	47,390	11
2000	47,756	12

2001 Accrual = $47,756 X 1.03 = $49,200 Rounded

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WILLOWCREEK REHAB AND NSG COUNTY ST. CLAIR

FACILITY IDPH LICENSE NUMBER 0041939

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-12-0-213-024	Long-Term Care Property	$ 47,755.76	$ 47,755.76
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 47,755.76	$ 47,755.76

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Brick Frame Brick Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 30,994
2. Number of Years Over Which it is Being Amortized: 5 Years
3. Current Period Amortization: 55,404
4. Dates Incurred: 1996, 1998 and 2000

Nature of Costs: $20,094 Organization Costs; $10,000 Loan Cost plus additional one-time loan costs relating to a prior loan
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1996	59,450		20	2,973	2,973	16,080	9
10	Various			1997	111,309		20	5,649	5,649	25,943	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		-	-		-		-	68
69	Financial Statement Depreciation			91,648			(91,648)		69
70	TOTAL (lines 4 thru 69)		$ 170,759	$ 91,648		$ 8,622	$ (83,026)	$ 42,023	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 170,759	$ 91,648		$ 8,622	$ (83,026)	$ 42,023	1
2	TILE	1998	2,222		20	111	111	444	2
3	R WEISEN-PAINTER	1998	1,449		20	72	72	288	3
4	R WEISEN-PAINTER	1998	1,503		20	75	75	294	4
5	CARPETING	1998	3,439		20	172	172	674	5
6	WALL PAPER	1998	884		20	44	44	172	6
7	GUTTERS	1998	983		20	49	49	192	7
8	ROOF WORK	1998	2,400		20	120	120	480	8
9	DOOR OPENERS	1998	531		20	27	27	101	9
10	PLUMBING	1998	1,295		20	65	65	238	10
11	GUTTER DRAINAGE SYST	1998	2,000		20	100	100	350	11
12	FLOOR TILE	1998	851		20	43	43	143	12
13	FLOORING	1998	1,947		20	97	97	315	13
14	FLOOR TILE	1998	2,110		20	106	106	345	14
15	COVE BASE	1998	703		20	35	35	114	15
16	T GRODEK	1998	2,375		20	119	119	367	16
17	HANDRAILS	1998	2,443		20	122	122	376	17
18	WALLPAPER	1998	1,797		20	90	90	278	18
19	PAINTING&DECORATING	1998	7,271		20	364	364	1,274	19
20	CONCRETE GENERATOR P	1999	2,325		20	116	116	348	20
21	GENERATOR	1999	28,102		20	1,405	1,405	4,215	21
22	GENERATOR WIRING	1999	16,900		20	845	845	2,535	22
23	TILE	1999	3,557		20	178	178	504	23
24	PLUMBING	1999	3,431		20	172	172	487	24
25	CHAIR RAILS	1999	1,134		20	57	57	157	25
26	ALUMINUM COLUMNS	1999	3,158		20	158	158	435	26
27	TILE	1999	1,823		20	91	91	250	27
28	WALL SINK	1999	1,156		20	58	58	160	28
29	PIPING	1999	2,050		20	103	103	292	29
30	CARPETING	1999	1,263		20	63	63	158	30
31	SHED	1999	3,176		20	159	159	398	31
32	GENERATOR MAINT	1999	2,343		20	117	117	283	32
33	FLOORING	1999	11,574		20	579	579	1,303	33
34	TOTAL (lines 1 thru 33)		$ 288,954	$ 91,648		$ 14,534	$ (77,114)	$ 59,993	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 288,954	$ 91,648		$ 14,534	$ (77,114)	$ 59,993	1
2	PAINTING & DECORATIN	1999	6,548		20	327	327	654	2
3	WALLPAPER & RAIL	1999	925		20	46	46	92	3
4	WALLPAPER & RAIL	1999	925		20	46	46	92	4
5	WALLPAPER & RAIL	1999	925		20	46	46	92	5
6	WALLPAPER & RAIL	1999	750		20	38	38	76	6
7	INSTALL DRAIN	1999	630		20	32	32	64	7
8	ECONOCARE DRAFTS	1999	14,757		20	738	738	1,476	8
9	COVE BASE	1999	524		20	26	26	52	9
10	ELECTRICAL WIRING	2000	2,722		20	70	70	137	10
11	FLOORING	2000	2,034		20	52	52	98	11
12	REPAIR GENERATOR	2000	2,059		20	53	53	82	12
13	ROOF REPAIR	2000	7,801		20	200	200	292	13
14	VENT UNIT MONITOR	2000	4,699		20	120	120	155	14
15	SEAL SERVICE ROAD	2000	2,170		20	56	56	63	15
16	A/C COMPRESSOR	2000	550		20	28	28	44	16
17	ANNUNCIATOR	2000	1,871		20	94	94	133	17
18	PAINTING & DECOR	2000	858		20	43	43	68	18
19	AIR DUCTS	2001	1,668		20	23	23	23	19
20	INSTALL COMPRESSOR	2001	1,389		20	20	20	20	20
21	INSTALL PANIC BARS	2001	1,298		20	15	15	15	21
22	INSTALL VENT MONITOR	2001	922		20	7	7	7	22
23	REPLC SEWER LINE	2001	2,235		20	7	7	7	23
24	INSTALL CORNER GUARD	2001	2,980		20	35	35	35	24
25	ANNUNCIATOR	2001	641		20	32	32	32	25
26	SECURITY LOCK	2001	600		20	30	30	30	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 351,435	$ 91,648		$ 16,718	$ (74,930)	$ 63,832	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 351,435	$ 91,648		$ 16,718	$ (74,930)	$ 63,832	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 351,435	$ 91,648		$ 16,718	$ (74,930)	$ 63,832	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 351,435	$ 91,648		$ 16,718	$ (74,930)	$ 63,832	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 351,435	$ 91,648		$ 16,718	$ (74,930)	$ 63,832	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 351,435	$ 91,648		$ 16,718	$ (74,930)	$ 63,832	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 351,435	$ 91,648		$ 16,718	$ (74,930)	$ 63,832	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 351,435	$ 91,648		$ 16,718	$ (74,930)	$ 63,832	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 351,435	$ 91,648		$ 16,718	$ (74,930)	$ 63,832	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 351,435	$ 91,648		$ 16,718	$ (74,930)	$ 63,832	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 351,435	$ 91,648		$ 16,718	$ (74,930)	$ 63,832	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 351,435	$ 91,648		$ 16,718	$ (74,930)	$ 63,832	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 351,435	$ 91,648		$ 16,718	$ (74,930)	$ 63,832	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
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60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$	$		$	$	$	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 330,106	$ 8,779	$ 37,903	$ 29,124	10	$ 116,488	71
72	Current Year Purchases	220,756	294	42,386	42,092	10	42,386	72
73	Fully Depreciated Assets	7,675				10	7,675	73
74								74
75	TOTALS	$ 558,537	$ 9,073	$ 80,289	$ 71,216		$ 166,549	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 909,972	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 100,721	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 97,007	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (3,714)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 230,381	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Belleville Associates

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		122	5/19/96	$ 414,594	15	N/A	3
4	Additions							4
5	Allocation from Quality Care				8,477			5
6								6
7	TOTAL		122		$ 423,071 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 5/31/96
Ending 5/31/11

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$ 424,958
13.	/2003	$ 435,582
14.	/2004	$ 446,472

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ 10,233 Description: $9376 Copier; $50 Icemaker; Allocation Quality Care $807
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 99,990	$		$ 99,990	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			36,855			36,855	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			516,720			516,720	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 03	# of prescrpts			9,512	216,705		226,217	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	39-01		397,279		4,322	532,061		933,662	13
14	TOTAL			$ 397,279		$ 667,399	$ 748,766		$ 1,813,444	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 31,309	$	1
2	Cash-Patient Deposits	24,656		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,028,800		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	36,314		6
7	Other Prepaid Expenses	6,284		7
8	Accounts Receivable (owners or related parties)	26,000		8
9	Other(specify): See supplemental schedule	107,892		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,261,255	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	297,147		15
16	Equipment, at Historical Cost	447,752		16
17	Accumulated Depreciation (book methods)	(343,316)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	23,225		19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 424,808	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,686,063	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,234,911	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,656		28
29	Short-Term Notes Payable	1,270,832		29
30	Accrued Salaries Payable	148,824		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,774		31
32	Accrued Real Estate Taxes(Sch.IX-B)	49,200		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	127,440		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,869,637	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,074,582		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,074,582	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,944,219	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,258,156)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,686,063	$	48

***(See instructions.)**

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (904,102)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (904,102)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(354,054)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (354,054)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,258,156)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,348,501	1
2	Discounts and Allowances for all Levels	(2,364,213)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,984,288	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,361,075	6
7	Oxygen	258,791	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,619,866	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	242,193	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	38,884	19
20	Radiology and X-Ray	15,302	20
21	Other Medical Services	188,179	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 484,558	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	958	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 958	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	2,440	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,440	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,092,110	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	791,132	31
32	Health Care	2,526,616	32
33	General Administration	1,463,826	33
	B. Capital Expense		
34	Ownership	769,357	34
	C. Ancillary Expense		
35	Special Cost Centers	1,828,438	35
36	Provider Participation Fee	66,795	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,446,164	40
41	**Income before Income Taxes (line 30 minus line 40)****	(354,054)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (354,054)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,942	2,486	$ 54,584	$ 21.96	1
2	Assistant Director of Nursing	11	12	255	21.25	2
3	Registered Nurses	19,758	28,693	596,250	20.78	3
4	Licensed Practical Nurses	31,437	34,026	581,488	17.09	4
5	Nurse Aides & Orderlies	72,714	79,106	765,315	9.67	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	14,545	15,594	397,279	25.48	7
8	Rehab/Therapy Aides	4,867	5,824	81,365	13.97	8
9	Activity Director	2,843	3,194	28,237	8.84	9
10	Activity Assistants	3,399	3,784	30,332	8.02	10
11	Social Service Workers	1,058	1,098	9,051	8.24	11
12	Dietician					12
13	Food Service Supervisor	1,948	2,086	28,318	13.58	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,916	22,352	147,059	6.58	15
16	Dishwashers					16
17	Maintenance Workers	5,324	5,726	79,427	13.87	17
18	Housekeepers	16,003	17,359	105,018	6.05	18
19	Laundry	9,031	9,496	55,606	5.86	19
20	Administrator	1,950	2,294	67,006	29.21	20
21	Assistant Administrator	707	707	10,611	15.01	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,992	11,623	114,303	9.83	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,942	3,148	27,670	8.79	31
32	Other Health Care(specify)					32
33	Other(specify)	468	592	14,994	25.33	33
34	TOTAL (lines 1 - 33)	222,855	249,200	$ 3,194,168 *	$ 12.82	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	180	$ 7,036	01-03	35
36	Medical Director	72	7,200	09-03	36
37	Medical Records Consultant	16	640	10-03	37
38	Nurse Consultant		1,125	10-03	38
39	Pharmacist Consultant	48	720	10-03	39
40	Physical Therapy Consultant	176	7,898	10a-03	40
41	Occupational Therapy Consultant	252	11,340	10a-03	41
42	Respiratory Therapy Consultant	180	18,000	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	66	3,300	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	990	$ 57,259		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	83	$ 2,864	10-03	50
51	Licensed Practical Nurses	169	4,780	10-03	51
52	Nurse Aides	7,192	92,082	10-03	52
53	TOTAL (lines 50 - 52)	7,444	$ 99,726		53

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Wolfgang Voltz	Administrator	0	$ 67,006
Kevin Presson, Robert Pecker	Weekend Admin	0	10,611
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 77,617

B. Administrative - Other

Description	Amount
Quality Care Management - Corporate Allocation	$ 278,881
TOTAL (agree to Schedule V, line 17, col. 3)	$ 278,881
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	Unemployment Consult.	$ 935
Frost, Ruttenberg & Rothblatt	Accounting	16,202
Systematic Mgmt. Systems	Billing	1,600
Econocare	Purchase Consultant	175
Accu-Med Services	Computer	2,457
GE Information Systems	Computer	443
Quality Care Mgmt.	Computer	4,000
RMS Business Systems	Computer	1,333
Health Data Systems	Computer	9,984
Sachnoff & Weaver	Legal	4,990
Barbara L. Greenberg	Legal	3,413
Winston & Strawn	Legal	1,814
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 47,346

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 70,566
Unemployment Compensation Insurance	23,816
FICA Taxes	241,535
Employee Health Insurance	122,554
Employee Meals	13,797
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	17,206
Employee Benefits	5,942
Holiday Expense	6,200
TOTAL (agree to Schedule V, line 22, col.8)	$ 501,616

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	8,581
Health Care Worker Background Check	
(Indicate # of checks performed)	
Dues and Subscriptions	11,588
Yellow Page Advertising	7,056
Licenses	599
Promotional Advertising	46,359
Allocation - Quality Care	3,514
Allocation - Boulevard	1,476
Less: Public Relations Expense	
Non-allowable advertising	(46,359)
Yellow page advertising	(7,056)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,758

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,159
Allocation - Quality Care	100
Allocation - Boulevard	178
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,437

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number WILLOWCREEK REHAB AND NSG # 0041939 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on LTC $6429**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,004** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? **X** YES ____ NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **66,795**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **13,797** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? ____ If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees